Methods and Standards for Establishing Payment Rates
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Narrative Explanation of Nursing Facility Reimbursement Formula

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	120% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimals, of the facility cost report period case mix indices for all Medicaid facilities calculated effective each payment rate period.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

The first step is to normalize each facility's Direct Health Care inflated per diem cost to the statewide average CMI. The following will describe the normalization process.

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Narrative Explanation of Nursing Facility Reimbursement Formula

A facility has an average inflated per diem cost of $60(**A**) and a facility cost report period CMI of 1.4000(**B**). The statewide average CMI is .9500(**C**). First, divide the statewide average CMI (**C**) by the facility cost report period CMI (**B**) (.9500/1.4000=.68). Second, the quotient is then multiplied by the average inflated per diem cost (**A**) to determine the normalized inflated cost at the statewide average CMI ($60 x .68= $40.80). Normalizing each facility's cost to the statewide average CMI ensures a level comparison of direct health care costs can be made when setting the upper payment limit.

The second step is to array the normalized inflated costs, based on the statewide average CMI, to determine the median. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are 8 million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $45 and the upper payment limit is based on 120% of the median, then the upper payment limit for the statewide average CMI would be $54 (**D**=120% x $45).

Once the base limit for the Direct Health Care cost center is established at the statewide average CMI, the base limit is adjusted by each facility's cost report period CMI to determine a facility specific Direct Health Care cost center upper payment limit. The following will describe the facility specific upper payment limit process. A facility has an average facility cost report period CMI of 1.4000(**A**). The statewide average CMI is .9500(**B**). First, divide the facility cost report period average CMI (**A**) by the statewide average CMI (**B**) (1.4000/.9500=1.47). Second, the statewide average CMI limit **D** ($54) is multiplied by the quotient to determine the upper payment limit for the facility ($54 x 1.47= $79.38). In the example above, the facility inflated Direct Health Care cost was $60, which is less than the upper payment limit of $79.38 for a facility average CMI of 1.4000.

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to

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determine the lower of the inflated Direct Health Care cost or the facility's specific Direct Health Care upper payment limit. Using the example in the Upper Payment Limit section, the Direct Health Care cost of $60 was less than the upper payment limit of $79.38 for an average CMI of 1.4000.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The Medicaid CMI is divided by the facility cost report period CMI. Using the example above, if the Medicaid average CMI is 1.6000, it is divided by 1.4000 to arrive at a quotient of 1.1400 (1.6000/1.4000). The lower of the inflated per diem cost or the facility specific Direct Health Care upper payment limit is multiplied by the quotient to determine the Medicaid acuity adjusted allowable Direct Health Care cost. In the example, the allowable Medicaid acuity adjusted Direct Health Care cost will be $68.40 ($60 x 1.1400).

For illustrative purposes, if the facility-specific upper payment limit had been $55 for an average CMI of 1.4000, the Medicaid rate would have been calculated using the upper payment limit since it was lower than the cost of $60. In this situation, the allowable Medicaid acuity adjusted cost would be $62.70 (1.1400 x $55).

The Direct Health Care component of the Medicaid rate is adjusted quarterly for changes in the Medicaid CMI. Using the first example above, if the average Medicaid CMI increases from 1.6000 to 1.7000 the following quarter, the allowance for the Direct Health Care cost would increase from $68.40 to $72.60. The first step is to divide the new average Medicaid CMI by the facility cost report period CMI established for the rate year (July 1 through June 30) to determine the new quotient (1.7000/1.4000=1.2100). The lower of the facility specific Direct Health Care upper payment limit or the inflated Direct Health Care per diem cost is multiplied by the new quotient to determine the Medicaid allowance. (1.21 x $60=$72.60).

Conversely, if the average Medicaid CMI decreases from 1.6000 to 1.5000 the following quarter, the allowance for the Direct Health Care cost would decrease from $68.40 to $64.20. Again, the first step is to divide the new average Medicaid CMI by the facility cost report period CMI established for the rate year (July 1 through June 30) to determine the new quotient (1.5000/1.4000=1.0700). The lower of the facility specific Direct Health Care upper payment limit or the inflated Direct Health Care per diem cost is multiplied by the new quotient to determine the Medicaid allowance. (1.0700 x $60=$64.20).

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8) Real And Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor.

All providers received a new property fee, effective July 1, 2002. The first step in determining a new facility-specific property fee was to sum the property allowance and value factor. The second step was to apply an annual inflation factor to the new property fee, consisting of the combined property allowance and value factor. The third step was to compare the inflated property fee to the upper payment limit established for the property fee. The provider received the lower of the facility-specific inflated property fee or the upper payment limit.

Additional inflation will be applied to the property fees, effective June 30, 2003. The property fees in effect June 1, 2003 were inflated 2.892%. The inflation factor was from the Data Resources, Inc.-WEFA, National Skilled Nursing Facility Total Market Basket Index (DRI Index). The inflation period was from July 1, 2002 through June 30, 2003. The providers received the lower of the inflated property fee or the upper payment limit of $6.11.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the

Kansas Medical Assistance program for the first time is explained in greater detail in Exhibit A-14 (K.A.R. 30-10-25).

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in Exhibit A-14 (K.A.R. 30-10-25). The rebased property fee is subject to the upper payment limit.

9) **Incentive Factor**

The incentive factor is a per diem add-on ranging from zero to fifty cents. It is based on the per diem cost of the Operating cost center less the real and personal property taxes expense line. The per diem allowance for this cost center less property taxes is determined before the owner/related party/administrator/co-administrator limitation is applied.

The incentive is designed to encourage economy and efficiency in the operating cost center. Property taxes are excluded. There is an inverse relationship between the incentive factor and the per diem cost used to determine it. The higher the per diem cost, the lower the incentive factor.

The Schedule E is an array of the per diem costs used to determine the incentive factor. The schedule includes costs from the base year historical cost report for all active providers. No projected cost reports are included. The 85% occupancy rule is applied in determining the per diem costs. The costs are not adjusted for inflation.

The Schedule E summarizes all expense lines from the Operating cost center, less property taxes. The ownership costs are excluded from the array so that both older facilities (with relatively lower ownership costs) and newer facilities (with relatively higher ownership costs) can benefit from the incentive factor through efficient operations.

The total per diem costs for the operating cost center, less property taxes, are arrayed and percentiles established. These percentiles then become the basis for establishing the per diem cost ranges used to determine each provider's efficiency factor, consistent with agency policy. The ranges are defined as follows:

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Providers Percentile Ranking	Incentive Factor Per Diem
-0- to 30th Percentile	$.50
31st to 55th Percentile	.40
56th to 75th Percentile	.30
76th to 100th Percentile	-0-

10) **Rate Effective Date**

Rate effective dates are determined in accordance with K.A.R. 30-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

11) **Retroactive Rate Adjustments**

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

And last, when a new provider, through an arms-length transaction that was recognized prior to June 30, 2003, is reimbursed the rate of the prior provider and files a historic cost report for the first 12 months of operation, a rate adjustment is made beginning with the first day after the cost report period. For example, if the first historic cost report is filed for the 12 month period ended June 30, but the rate from the cost report is not entered into the payment system until October 1, then there will be a retroactive rate adjustment from July 1 through September 30. New providers recognized effective June 30, 2003 or after will be paid a rate determined from the previous provider's cost report data for the first 24 months of operation.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

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12) **Comparable Private Pay Rates**

The last factor considered in determining a provider's Medicaid per diem payment rate is their private pay rate. Providers are reimbursed the lower of the calculated Medicaid rate or their private pay rate. The agency maintains a registry of private pay rates. It is the responsibility of the providers to send in private pay rate updates so that the registry is updated. When new Medicaid rates are determined, if the private pay rate reflected in the registry is lower, then the provider is held to that private pay rate until the provider sends notification that it has a higher private pay rate.

Case Mix Adjustments to Private Pay Rates:

Private pay rates submitted to the agency are adjusted up if a provider's average private pay/other CMI is lower than its Medicaid average CMI. This is accomplished by multiplying the provider's average private pay rate in the private pay registry by the ratio of their Medicaid average CMI to their average private pay/other CMI. This ensures that providers' Medicaid rates are not limited to a lower private pay rate that may be attributed to the lower acuity of the private pay residents. There is no adjustment to private pay rates if the facility's Medicaid average CMI is less than its average private pay/other CMI. There is also no adjustment to private pay rates if the facility's total Medicaid rate is less than its average private pay rate

KANSAS MEDICAID STATE PLAN

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KANSAS MEDICAID / MEDIKAN

CASE MIX SCHEDULE
1ST QRT 2004
PAGE 1

****** PROVIDER INFORMATION ******

PROVIDER NO.....

FACILITY NAME.....
ADDRESS.....
CITY/STATE/ZIP....
ADMINISTRATOR.....

REPORT YEAR END... 12/31/2001
FISCAL YEAR END... 12/31/2001

INFLATION FACTOR.. 4.197

FACILITY COST REPORT PERIOD CMI	0.6897 (A)
STATEWIDE AVERAGE CMI	0.9197 (B)
MEDICAID CMI	0.6927 (C)
MEDICARE CMI	0.0000
PRIVATE PAY CMI	0.6742

BEDS AVAILABLE	PRIOR	CURRENT	%CHG
NF OR NF/MH BEDS.....	48	52	8.3
ASSISTED LIVING BEDS...	14	14	0.0
UNLICENSED BEDS.....	0	0	0.0
BED DAYS AVAILABLE.....	19,520	18,980	-2.8
INPATIENT DAYS.....	16,792	16,396	-2.4
OCCUPANCY RATE.....	86.0	86.4	0.5
MEDICAID DAYS.....	13,734	12,791	-6.9
CAL DAYS IF APPL.....	0	0	
OPER DAYS USED IN DIV..	16,792	16,396	
IDHC DAYS USED IN DIV..	16,792	16,396	
DHC DAYS USED IN DIV...	16,792	16,396	

****** CALCULATION OF REIMBURSEMENT RATE ******

----OPERATING----	
TOTAL OPERATING COST	290,857
OPER PER DIEM COST	17.74
INFLATION	0.68
OPER PER DIEM COST BEFORE LIMIT	18.42
OPER PER DIEM COST LIMITATION	20.32
OPER PER DIEM RATE	18.42

----INDIRECT HEALTH CARE----	
TOTAL IDHC COST	399,346
IDHC PER DIEM COST	24.36
INFLATION	1.03
IDHC PER DIEM COST BEFORE LIMIT	25.39
IDHC PER DIEM COST LIMITATION	33.35
IDHC PER DIEM RATE	25.39

----DIRECT HEALTH CARE----		
TOTAL DHC COST	551,736	
DHC PER DIEM COST	33.65	(D)
INFLATION	1.41	(E)
DHC PER DIEM COST BEFORE LIMIT	35.06	(F) [D+E]
DHC PER DIEM COST LIMITATION	61.78	(G)
FACILITY SPECIFIC DHC PER DIEM COST LIMIT	46.33	(H) [G*(A/B)]
ALLOWABLE DHC PER DIEM COST	35.06	(I) [MIN(H,F)]
MEDICAID ACUITY ADJUSTMENT	35.21	(J) [I*(C/A)]

----REAL AND PERSONAL PROPERTY FEE----	
REAL AND PERSONAL PROP FEE	4.11
INFLATION (2.892)	0.12
RPPF RELEASE ADD ON	0.00
RPPF BEFORE LIMIT	4.23
RPPF LIMITATION	6.11
ALLOWABLE RPPF	4.23

		HN
OPERATING, IDHC, AND DHC RATES.....		79.02
INCENTIVE FACTOR.....		0.40
ALLOWABLE REAL AND PERSONAL PROPERTY FEE....		4.23
WAGE PASS THROUGH		0.00
TOTAL REIMBURSEMENT RATE EFFECTIVE.....	06/30/2003	83.65
PRIVATE PAY RATE (REGISTER).....	01/01/2003	93.24
PRIVATE PAY RATE (MEDICAID ADJUSTMENT)....	01/01/2003	95.82

KANSAS MEDICAID STATE PLAN

Attachment 4.19-D
Part I
Subpart C
Exhibit C-5
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EXPENSE STATEMENT

DESCRIPTION	LINE NO.	CURRENT YEAR REPORTED EXPENSE	PROVIDER ADJUSTMT	SRS ADJUSTMT	CURRENT YEAR RESIDENT EXPENSE	CURRENT YEAR PER DAY	PRIOR YEAR RESIDENT EXPENSE	PRIOR YEAR PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
OPERATING											
SALARY-ADMIN	101	46,551	0	0	46,551	2.84	41,006	2.50	13.60	101	
SALARY-CO ADM	102	0	0	0	0	0.00	0	0.00	0.00	102	
OTHER ADM SAL	103	22,150	0	2,948	25,098	1.52	21,711	1.29	16.60	103	Note Attached
EMP BENEFITS	104	12,686	0	0	12,686	0.77	11,794	0.70	10.00	104	
OFC SUP & PRINT	105	6,200	0	0	6,200	0.38	6,379	0.38	0.00	105	
MGT CONSULTING	106	98,483	-98,483	0	0	0.00	0	0.00	0.00	106	
OWN/REL PTY CHP	107	0	24,140	-2,948	21,192	1.29	25,779	1.54	-16.23	107	Note Attached
CENTRAL OFC	108	0	80,174	-3,106	77,068	4.70	66,079	4.05	16.05	108	Note Attached
PHONE & COMMUNI	109	16,663	0	0	16,663	1.02	9,366	0.56	82.14	109	
TRAVEL	110	1,595	0	0	1,595	0.10	1,387	0.08	25.00	110	
ADVERTISING	111	2,827	0	0	2,827	0.17	1,780	0.11	54.55	111	
LICENSES & DUES	112	4,050	0	0	4,050	0.25	2,649	0.16	56.25	112	
LEGAL/ACCTG OP	113	0	0	0	0	0.00	0	0.00	0.00	113	
LIABILITY INSUR	114a	9,108	0	0	9,108	0.56	18,604	1.11	-49.55	114a	
OTHER INSURANCE	114b	9,747	0	0	9,747	0.59	0	0.00	0.00	114b	
INT EXCEPT R/E	115	911	0	-447	464	0.03	1,331	0.08	-62.50	115	Note Attached
LEGAL	116	144	0	0	144	0.01	0	0.00	100.00	116	
CRIM BKGD CHECC	117	503	0	0	503	0.03	165	0.01	200.00	117	
OTHER	118	556	0	0	556	0.03	1,085	0.06	-50.00	118	
O/A LIMIT	119	0	0	-9,537	-9,537	-0.58	-7,402	-0.44	31.82	119	
R/E & PP TAXES	121	11,280	0	0	11,280	0.69	10,988	0.65	5.45	121	
SALARIES	126	12,148	0	0	12,148	0.74	11,758	0.70	5.71	126	
EMP BENEFITS	127	1,366	0	0	1,366	0.08	1,428	0.09	-11.11	127	
OWN/REL PTY CHP	128	0	0	0	0	0.00	0	0.00	0.00	128	
MAINT & REPAIR	130	8,513	0	0	8,513	0.52	16,927	1.13	-33.98	130	
SUPPLIES	131	25,793	0	0	25,793	1.57	22,222	1.32	18.94	131	
SMALL EQUIPMENT	137	1,808	0	0	1,808	0.11	2,957	0.18	-38.89	137	
OTHER	138	5,035	0	0	5,035	0.31	5,830	0.35	-11.43	138	
TOTAL OPERATING		298,117	5,831	-13,090	290,857	17.74	278,723	16.60	6.87		
INDIRECT HEALTH CARE											
UTILITIES	129	29,380	0	0	29,380	1.79	29,616	1.76	1.70	129	
EMP BENEFITS	141	15,858	0	0	15,858	0.97	12,981	0.77	25.97	141	
DIETARY-SAL	142	82,113	0	0	82,113	5.01	71,938	4.28	17.06	142	
OWN/REL PTY CHP	143	0	0	0	0	0.00	0	0.00	0.00	143	
CONSULTANT	144	0	0	0	0	0.00	1,655	0.10	-0.00	144	
FOOD	145	63,082	0	0	63,082	3.85	55,298	3.29	17.02	145	
SUPPLIES	146	3,538	0	0	3,538	0.22	2,938	0.17	29.41	146	
OTHER	148	622	0	0	622	0.04	635	0.04	0.00	148	
LAUNDRY-LINEN-SAL	149	14,839	0	0	14,839	0.91	18,999	1.13	-19.47	149	
LINEN - BEDDING	150	1,080	0	0	1,080	0.07	1,282	0.08	-12.30	150	
SUPPLIES	151	2,401	0	0	2,401	0.15	4,566	0.27	-44.44	151	
OTHER	153	561	0	0	561	0.03	572	0.03	0.00	153	
HOUSEKEEPING-SAL	154	52,465	0	0	52,465	3.20	40,151	2.39	33.89	154	
SUPPLIES	155	8,120	0	0	8,120	0.50	10,533	0.63	-20.63	155	
OTHER	158	2,011	0	0	2,011	0.12	2,542	0.15	-20.00	158	
ALLOC OF EMP BEN	164	8,002	0	0	8,002	0.49	5,483	0.34	44.12	164	
BARBER AND BEAUTY	170	0	0	0	0	0.00	0	0.00	0.00	170	
THPY/OTHER SAL	171a	1,978	0	0	1,978	0.12	391	0.02	415.36	171a	
THPY/OTHER SAL	171b	0	0	0	0	0.00	70	0.00	0.00	171b	
THPY/OTHER SAL	171c	75	0	0	75	0.00	0	0.00	0.00	171c	
THPY/OTHER SAL	171d	0	0	0	0	0.00	0	0.00	0.00	171d	

KANSAS MEDICAID STATE PLAN

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PROV NUM

* * * * * * EXPENSE STATEMENT * * * * * *

DESCRIPTION	LINE NO.	CURRENT YEAR REPORTED EXPENSE	CURRENT YEAR PROVIDER ADJUSTMT	CURRENT YEAR SRS ADJUSTMT	CURRENT YEAR RESIDENT EXPENSE	CURRENT YEAR PER DAY	PRIOR YEAR RESIDENT EXPENSE	PRIOR YEAR PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
INDIRECT HEALTH CARE(CONT'D)											
THPY/OTHER SAL	171e	0	0	0	0	0.00	0	0.00	0.00	171e	
THPY/OTHER SAL	171f	0	0	0	0	0.00	0	0.00	0.00	171f	
OWN/REL PTY CMP	172	0	0	0	0	0.00	0	0.00	0.00	172	
PAT ACT/SOC WKR	173a	22,541	0	0	22,541	1.37	21,731	1.29	6.20	173a	
PAT ACT/SOC WKR	173b	23,324	0	0	23,324	1.42	21,488	1.28	10.94	173b	
PAT ACT/SOC WKR	173c	19,692	0	0	19,692	1.20	9,380	0.56	114.29	173c	
PAT ACT/SOC WKR	173d	0	0	0	0	0.00	0	0.00	0.00	173d	
PAT ACT SUPPLS	174	21,510	0	0	21,510	1.31	20,533	1.22	7.38	174	
OCCUP THERAPY	175	0	0	0	0	0.00	0	0.00	0.00	175	
MED RECORDS-CON	176	1,169	0	0	1,169	0.07	321	0.02	250.00	176	
PHARM-CONSULTANTS	177	900	0	0	900	0.05	975	0.06	-16.67	177	
SPEECH THERAPY	178	0	0	0	0	0.00	0	0.00	0.00	178	
PHYSICAL THERAPY	179	0	0	0	0	0.00	0	0.00	0.00	179	
CONSULTANT	180	0	0	0	0	0.00	41	0.00	0.00	180	
NURSING TRNG	181a	2,698	0	0	2,698	0.16	0	0.00	100.00	181a	
NURSING TRNG	181b	0	0	0	0	0.00	1,609	0.10	0.00	181b	
RESIDENT TRANSP	182	11,297	0	0	11,297	0.69	6,366	0.38	81.58	182	
OTHER	183	7,866	0	0	7,866	0.48	7,127	0.42	14.29	183	
OTHER	188	0	2,224	0	2,224	0.14	0	0.00	100.00	188	
TOTAL INDIRECT HC		397,122	2,224	0	399,346	24.36	349,218	20.80	17.12		
DIRECT HEALTH CARE											
NURSING-RN	161	123,075	0	0	123,075	7.51	124,597	7.42	1.21	161	
LPN/LMHT	162a	136,653	0	0	136,653	8.33	144,705	8.62	-3.36	162a	
LPN/LMHT	162b	0	0	0	0	0.00	0	0.00	0.00	162b	
OTHER NURSING	163a	156,897	0	0	156,897	9.57	149,339	8.89	7.65	163a	
OTHER NURSING	163b	58,244	0	0	58,244	3.55	54,812	3.26	8.90	163b	
OTHER NURSING	163c	0	0	0	0	0.00	0	0.00	0.00	163c	
ALLOC OF EMP BEN	164	56,204	0	0	56,204	3.43	48,931	3.06	12.09	164	
OWN/REL PTY CMP	165	0	0	0	0	0.00	0	0.00	0.00	165	
CONSULTANTS	166	0	0	0	0	0.00	0	0.00	0.00	166	
PURCH SERVICES	167	0	0	0	0	0.00	0	0.00	0.00	167	
SUPPLIES	168	20,663	0	0	20,663	1.26	23,024	1.37	-8.03	168	
TOTAL DIRECT HC		551,736	0	0	551,736	33.65	545,408	32.48	3.60		
TOTAL ALLOWABLE	190	1,246,976	8,055	-13,090	1,241,940	75.75	1,173,349	69.88	8.40	190	
OWNERSHIP											
INT-R/E MORTG	191	0	0	0	0	0.00	0	0.00	0.00	191	
RENT/LEASE	192	53,432	0	0	53,432	3.26	42,039	2.50	30.40	192	
LEASEHOLD IMPRV	193	0	0	0	0	0.00	0	0.00	0.00	193	
DEPRECIATION	194	9,978	-216	0	9,762	0.60	7,931	0.47	27.66	194	
TOTAL OWNERS	195	63,410	-216	0	63,194	3.85	49,990	2.98	29.19		

REAL AND PERSONAL PROPERTY FEE REBASE ADD ON

EFF DATE	RES DAYS	INTEREST	DEPR	TOTAL	REBASE PER DIEM ADD ON
07/01/1986	28,590	28,459	62,442	90,901	0.00